

AMENDED IN SENATE JUNE 18, 2009

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

ASSEMBLY BILL

No. 684

Introduced by Assembly Member Ma
(Coauthors: Assembly Members Tom Berryhill and Skinner)

February 26, 2009

An act to amend Section 1371 of the Health and Safety Code, and to amend Section 10123.13 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 684, as amended, Ma. Claim reimbursement: late payments: dental services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Under existing law, health care service plans and health insurers are required to reimburse ~~uncontested claims no later than~~ *claims within 30 or 45 working days, as specified, after receipt of the claim, and if specified.* If a claim is not reimbursed within that time period, existing law requires that interest accrue at the rate of 15% per annum, for health care service plans, and 10% per annum, for health insurers.

With respect to contracts or policies covering dental services, this bill would increase the interest rate if ~~uncontested~~ *the claims are not reimbursed within 60 or 90 working days after receipt, as specified, and would require the additional interest to be paid to the Department*

of Managed Health Care or the Department of Insurance to be used for the purpose of enforcing specified claim practice provisions.

Existing law specifies that a claim is contested if the plan or insurer has not received a completed claim and all information necessary to determine payer liability. A plan is required to notify a claimant of a contested claim within a specified period of time.

With respect to contracts or policies covering dental services, this bill would require the plan or insurer to include a request for the additional information in the contested claim notice. The bill would also require the plan or insurer to acknowledge receipt of the additional information within specified periods of time.

Because a willful violation of the bill's provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1371 of the Health and Safety Code is
2 amended to read:
3 1371. (a) A health care service plan, including a specialized
4 health care service plan, shall reimburse claims or any portion of
5 any claim, whether in state or out of state, as soon as practical, but
6 no later than 30 working days after receipt of the claim by the
7 health care service plan, or if the health care service plan is a health
8 maintenance organization, 45 working days after receipt of the
9 claim by the health care service plan, unless the claim or portion
10 thereof is contested by the plan in which case the claimant shall
11 be notified, in writing, that the claim is contested or denied, within
12 30 working days after receipt of the claim by the health care service
13 plan, or if the health care service plan is a health maintenance
14 organization, 45 working days after receipt of the claim by the
15 health care service plan. The notice that a claim is being contested

1 shall identify the portion of the claim that is contested and the
2 specific reasons for contesting the claim.

3 (b) If an uncontested claim is not reimbursed by delivery to the
4 claimant's address of record within the respective 30 or 45 working
5 days after receipt, interest shall accrue at the rate of 15 percent per
6 annum beginning with the first calendar day after the 30- or
7 45-working-day period.

8 (c) With respect to a health care service plan contract covering
9 dental services or a specialized health care service plan contract
10 covering dental services pursuant to this chapter, in addition to
11 subdivision (b), both of the following shall apply:

12 (1) If an uncontested claim is not reimbursed by delivery to the
13 claimant's address of record within 60 working days after receipt,
14 interest shall accrue at the rate of 20 percent per annum beginning
15 with the first calendar day after the 60-working-day period.

16 (2) If an uncontested claim is not reimbursed by delivery to the
17 claimant's address of record within 90 working days after receipt,
18 interest shall accrue at the rate of 25 percent per annum beginning
19 with the first calendar day after the 90-working-day period.

20 (d) *The interest that accrues in excess of 15 percent per annum*
21 *pursuant to subdivision (c) and subparagraph (D) of paragraph*
22 *(3) of subdivision (g) shall be paid to the department and,*
23 *notwithstanding subdivision (b) of Section 1341.45, shall be*
24 *deposited in the Managed Care Fund. These moneys shall, upon*
25 *appropriation, be used for the purposes of enforcing Section*
26 *1371.37.*

27 ~~(d)~~

28 (e) A health care service plan shall automatically include in its
29 payment of the claim all interest ~~that has accrued~~ *payable to the*
30 *claimant* pursuant to this section without requiring the claimant
31 to submit a request for the interest amount. Any plan failing to
32 comply with this requirement shall pay the claimant a ten dollar
33 (\$10) fee.

34 ~~(e)~~

35 (f) For the purposes of this section, a claim, or portion thereof,
36 is reasonably contested where the plan has not received the
37 completed claim and all information necessary to determine payer
38 liability for the claim, or has not been granted reasonable access
39 to information concerning provider services. Information necessary
40 to determine payer liability for the claim includes, but is not limited

1 to, reports of investigations concerning fraud and
2 misrepresentation, and necessary consents, releases, and
3 assignments, a claim on appeal, or other information necessary for
4 the plan to determine the medical necessity for the health care
5 services provided.

6 ~~(f)~~

7 (g) (1) If a claim or portion thereof is contested on the basis
8 that the plan has not received all information necessary to
9 determine payer liability for the claim or portion thereof and notice
10 has been provided pursuant to this section, then the plan shall have
11 30 working days or, if the health care service plan is a health
12 maintenance organization, 45 working days after receipt of this
13 additional information to complete reconsideration of the claim.

14 ~~h~~

15 (2) If a plan has received all of the information necessary to
16 determine payer liability for a contested claim and has not
17 reimbursed a claim it has determined to be payable within 30
18 working days of the receipt of that information, or if the plan is a
19 health maintenance organization, within 45 working days of receipt
20 of that information, interest shall accrue and be payable at a rate
21 of 15 percent per annum beginning with the first calendar day after
22 the 30- or 45-working day period.

23 (3) *With respect to a health care service plan contract covering*
24 *dental services or a specialized health care service plan contract*
25 *covering dental services pursuant to this chapter, if a claim or*
26 *portion thereof is contested on the basis that the plan has not*
27 *received all information necessary to determine payer liability for*
28 *the claim or portion thereof, all of the following shall apply:*

29 (A) *The notice required under this section that the claim or*
30 *portion thereof is being contested shall include a written request*
31 *for the necessary information and a clear and accurate explanation*
32 *of the necessity for that information.*

33 (B) *The plan shall acknowledge receipt of any information*
34 *requested pursuant to this paragraph as follows:*

35 (i) *In the case of information that the claimant submits*
36 *electronically, the plan shall acknowledge receipt of the*
37 *information within two working days of receipt of the information*
38 *by the office designated to receive the claim.*

39 (ii) *In the case of information that the claimant submits in paper*
40 *form, the plan shall acknowledge receipt of the information within*

1 15 working days of receipt of the information by the office
2 designated to receive the claim.

3 (C) Upon receipt of all of the information requested pursuant
4 to this paragraph, the plan shall process or deny the claim or
5 portion thereof within the timeframes specified in paragraph (1).

6 (D) In addition to paragraph (2), both of the following shall
7 apply:

8 (i) If the plan has received all of the information necessary to
9 determine payer liability for a contested claim and has not
10 reimbursed a claim it has determined to be payable within 60
11 working days of the receipt of that information, interest shall
12 accrue and be payable at a rate of 20 percent per annum beginning
13 with the first calendar day after the 60-working day period.

14 (ii) If the plan has received all of the information necessary to
15 determine payer liability for a contested claim and has not
16 reimbursed a claim it has determined to be payable within 90
17 working days of the receipt of that information, interest shall
18 accrue and be payable at a rate of 25 percent per annum beginning
19 with the first calendar day after the 90-working day period.

20 ~~(g)~~

21 (h) The obligation of the plan to comply with this section shall
22 not be deemed to be waived when the plan requires its medical
23 groups, independent practice associations, or other contracting
24 entities to pay claims for covered services.

25 SEC. 2. Section 10123.13 of the Insurance Code is amended
26 to read:

27 10123.13. (a) Every insurer issuing group or individual policies
28 of health insurance that covers hospital, medical, or surgical
29 expenses, including those telemedicine services covered by the
30 insurer as defined in subdivision (a) of Section 2290.5 of the
31 Business and Professions Code, shall reimburse claims or any
32 portion of any claim, whether in state or out of state, for those
33 expenses as soon as practical, but no later than 30 working days
34 after receipt of the claim by the insurer unless the claim or portion
35 thereof is contested by the insurer, in which case the claimant shall
36 be notified, in writing, that the claim is contested or denied, within
37 30 working days after receipt of the claim by the insurer. The
38 notice that a claim is being contested or denied shall identify the
39 portion of the claim that is contested or denied and the specific
40 reasons including for each reason the factual and legal basis known

1 at that time by the insurer for contesting or denying the claim. If
2 the reason is based solely on facts or solely on law, the insurer is
3 required to provide only the factual or the legal basis for its reason
4 for contesting or denying the claim. The insurer shall provide a
5 copy of the notice to each insured who received services pursuant
6 to the claim that was contested or denied and to the insured's health
7 care provider that provided the services at issue. The notice shall
8 advise the provider who submitted the claim on behalf of the
9 insured or pursuant to a contract for alternative rates of payment
10 and the insured that either may seek review by the department of
11 a claim that the insurer contested or denied, and the notice shall
12 include the address, Internet Web site address, and telephone
13 number of the unit within the department that performs this review
14 function. The notice to the provider may be included on either the
15 explanation of benefits or remittance advice and shall also contain
16 a statement advising the provider of its right to enter into the
17 dispute resolution process described in Section 10123.137. The
18 notice to the insured may also be included on the explanation of
19 benefits.

20 (b) If an uncontested claim is not reimbursed by delivery to the
21 claimant's address of record within 30 working days after receipt,
22 interest shall accrue and shall be payable at the rate of 10 percent
23 per annum beginning with the first calendar day after the
24 30-working day period.

25 (c) With respect to a health insurance policy covering dental
26 services or a specialized health insurance policy covering dental
27 services, in addition to subdivision (b), both of the following shall
28 apply:

29 (1) If an uncontested claim is not reimbursed by delivery to the
30 claimant's address of record within 60 working days after receipt,
31 interest shall accrue at the rate of 20 percent per annum beginning
32 with the first calendar day after the 60-working day period.

33 (2) If an uncontested claim is not reimbursed by delivery to the
34 claimant's address of record within 90 working days after receipt,
35 interest shall accrue at the rate of 25 percent per annum beginning
36 with the first calendar day after the 90-working day period.

37 (d) *The interest that accrues in excess of 10 percent per annum*
38 *pursuant to subdivision (c) and subparagraph (D) of paragraph*
39 *(3) of subdivision (e) shall be paid to the department and deposited*
40 *in the Insurance Fund. Notwithstanding Section 12975.7, these*

1 *moneys shall, upon appropriation, be used for the purposes of*
2 *enforcing Section 10133.66.*

3 ~~(d)~~

4 *(e) (1) For purposes of this section, a claim, or portion thereof,*
5 *is reasonably contested when the insurer has not received a*
6 *completed claim and all information necessary to determine payer*
7 *liability for the claim, or has not been granted reasonable access*
8 *to information concerning provider services. Information necessary*
9 *to determine liability for the claims includes, but is not limited to,*
10 *reports of investigations concerning fraud and misrepresentation,*
11 *and necessary consents, releases, and assignments, a claim on*
12 *appeal, or other information necessary for the insurer to determine*
13 *the medical necessity for the health care services provided to the*
14 *claimant.*~~If~~

15 *(2) If an insurer has received all of the information necessary*
16 *to determine payer liability for a contested claim and has not*
17 *reimbursed a claim determined to be payable within 30 working*
18 *days of receipt of that information, interest shall accrue and be*
19 *payable at a rate of 10 percent per annum beginning with the first*
20 *calendar day after the 30-working day period.*

21 *(3) With respect to a health insurance policy covering dental*
22 *services or a specialized health insurance policy covering dental*
23 *services, if a claim or portion thereof is contested on the basis that*
24 *the insurer has not received all information necessary to determine*
25 *payer liability for the claim or portion thereof, all of the following*
26 *shall apply:*

27 *(A) The notice required under this section that the claim or*
28 *portion thereof is being contested shall include a written request*
29 *for the necessary information and a clear and accurate explanation*
30 *of the necessity for that information.*

31 *(B) The insurer shall acknowledge receipt of any information*
32 *requested pursuant to this paragraph as follows:*

33 *(i) In the case of information that the claimant submits*
34 *electronically, the insurer shall acknowledge receipt of the*
35 *information within two working days of receipt of the information*
36 *by the office designated to receive the claim.*

37 *(ii) In the case of information that the claimant submits in paper*
38 *form, the insurer shall acknowledge receipt of the information*
39 *within 15 working days of receipt of the information by the office*
40 *designated to receive the claim.*

1 (C) Upon receipt of all of the information requested pursuant
2 to this paragraph, the insurer shall process or deny the claim
3 within the timeframe specified in paragraph (2).

4 (D) In addition to paragraph (2), both of the following shall
5 apply:

6 (i) If the insurer has received all of the information necessary
7 to determine payer liability for a contested claim and has not
8 reimbursed a claim it has determined to be payable within 60
9 working days of the receipt of that information, interest shall
10 accrue and be payable at a rate of 20 percent per annum beginning
11 with the first calendar day after the 60-working day period.

12 (ii) If the insurer has received all of the information necessary
13 to determine payer liability for a contested claim and has not
14 reimbursed a claim it has determined to be payable within 90
15 working days of the receipt of that information, interest shall
16 accrue and be payable at a rate of 25 percent per annum beginning
17 with the first calendar day after the 90-working day period.

18 ~~(e)~~

19 (f) The obligation of the insurer to comply with this section shall
20 not be deemed to be waived when the insurer requires its
21 contracting entities to pay claims for covered services.

22 SEC. 3. No reimbursement is required by this act pursuant to
23 Section 6 of Article XIII B of the California Constitution because
24 the only costs that may be incurred by a local agency or school
25 district will be incurred because this act creates a new crime or
26 infraction, eliminates a crime or infraction, or changes the penalty
27 for a crime or infraction, within the meaning of Section 17556 of
28 the Government Code, or changes the definition of a crime within
29 the meaning of Section 6 of Article XIII B of the California
30 Constitution.